Georgia Department of Community Health

EXPRESS SCRIPTS® Charting the Future of Pharmacy

Georgia Watch Form
for Medicaid & PeachCare

6625 W. 78th Street ~BL0345
Bloomington, MN 55439
All other Prior Authorization
Requests: PH # 1-877-650-9340

FAX TO: 877-697-7192

Today's Date_____

Note: If all of the following information is NOT filled in completely, correctly, or legibly the authorization process **will be delayed**.

First **Middle** **Last**

Member Full Name _____

Member ID#_____ **Member Date of Birth** _____/_____/_____

Medication Requested_____ **Strength** _____ **Dosage Form** _____

Quantity _____ **Directions** _____

Generic Products Tried? **(circle one)** NO or YES **If Yes, list names of Manufacturers.**

1. _____ 2. _____ 3. _____

What was the Patient's response to each generic product? **(a response description MUST be given)**

Product Name Response

1. _____ ☐ Subtherapeutic Response ☐ Allergy ☐ Side Effect ☐ Other

Response Description_____

2. _____ ☐ Subtherapeutic Response ☐ Allergy ☐ Side Effect ☐ Other

Response Description_____

3. _____ ☐ Subtherapeutic Response ☐ Allergy ☐ Side Effect ☐ Other

Response Description_____

Physician Name (please print clearly) _____

Physician Signature _____

State License number (required)_____

Physician Address_____

Physician Phone (_____)_____ - _____ **Physician Fax(_____)_____ - _____**

Office Contact Person_____ **Signature** _____

Any further information pertaining to this drug request should be included and attached to this form.

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